Instructions to File a Claim for Disability Benefits

1. Complete all Sections of the Employee Statement.
2. Read the Tax Notice and complete it for voluntary Federal Income Tax withholding from disability benefit payments.
3. Ask your Doctor to complete an Attending Physician's Statement.
4. Submit these completed forms according to the directions you received from your Benefits Office.
5. If the Prudential Insurance Company of America ("Prudential") provides you with both short term and long term disability benefits, the claim for long term disability benefits will be considered as having been filed when the eligibility requirements for that coverage have been met. If you are unclear about whether or not Prudential provides you with both types of disability benefits, please consult your employer.

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Voice: 1-800-842-1718
Facsimile: 1-877-889-4885

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

For your protection, certain state laws require the following to appear on this form:

CALIFORNIA RESIDENTS - For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW JERSEY RESIDENTS - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Prudential Financial

Group Disability Insurance Employee Statement

1 Employer Information

Employer Name: Montgomery County Government

Control Number: 94659

Location / Division

Branch Number

2 Employee Information

First Name | MI | ***Social Security Number*** ___ - ___ - ____

Last Name | Suffix

Mailing Address - Line 1

Mailing Address - Line 2

Birth date (MM/DD/Year) __ / __ / ____

City | State | Zip Code ____ - ____

Gender: ○ Male ○ Female

Marital Status: ○ Unmarried ○ Married ○ Divorced ○ Widowed

Primary Phone Number ___ - ___ - ____

Work Phone Number ___ - ___ - ____

Email Address

Date Last Worked (MM/DD/Year) __ / __ / ____

Date First Absent __ / __ / ____

Date First Treated for this Condition __ / __ / ____

Date Expected to Return to Work __ / __ / ____

Spouses Date of Birth __ / __ / ____

Is Spouse Employed? ○ Yes ○ No

EDUCATION: Highest Grade Completed:

Number of Children Under 18:

Age of Youngest Child:

3 Job Information

Occupation

What Job Category best describes your required job duties? (Please check appropriate box)

○ Sedentary	○ Light	○ Medium	○ Heavy	○ Very Heavy	○ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

4 Primary Care Physician

Physician Name | Primary Phone Number ___ - ___ - ____

Street Address | Fax Number ___ - ___ - ____

City | State | Zip Code ____ - ____

For Internal Use Only

Claim Number

* 1 0 1 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance Employee Statement

Employee Last Name

Social Security Number ___ - __ - ____

5 Medical Information

All Other Physicians You Have Consulted for this Condition

Physician Name	Specialty	Phone Number

What medical condition is preventing you from working?_____

_____

How does this condition interfere with your ability to perform your job?_____

_____

Have you been hospitalized for this condition? ○ Yes ○ No ○ In-Patient ○ Out-Patient

If hospitalized, give dates:
From: __ / __ / ____
To: __ / __ / ____

If you are pregnant: Estimated Delivery Date __ / __ / ____ Actual Delivery Date __ / __ / ____

Name of Your Health Insurance Company

Telephone Number ___ - ___ - ____

6 Other Income & Workers' Comp. Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.) Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance	○	○				
State Disability Benefits	○	○				
Workers' Compensation	○	○				
Other:	○	○				
Other:	○	○				

Is this condition work related? ○ Yes ○ No If Yes, do you intend to file a Workers' Compensation claim? ○ Yes ○ No

7 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. (Please see state specific fraud warnings attached.)

X _____ __ / __ / ____

Employee Signature Date Signed

Prudential Financial

Group Disability Insurance Authorization

1

Claimant Information

Social Security Number ___ - ___ - ____

Employee Phone Number ___ - ___ - ____

First Name

MI

Last Name

Suffix

Email Address

Employer Name

Control Number

Montgomery County Government 94659

2

Authorization to Release Information

Authorization for Release of Information to Prudential Insurance Company
This Authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at : PO Box 13480, Philadelphia, PA 19101. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any: _____

_____

X _____ Claimant Signature

__ / __ / ____ Date Signed

Notice to Montana residents: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

For Internal Use Only

Claim Number

* 1 0 5 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Employee Tax Notice

1

Employee Information

Social Security Number ___ - ___ - ____

Employee Phone Number ___ - ___ - ____

First Name _____ MI _

Last Name _____ Suffix ___

Email Address _____

Employer Name: Montgomery County Government

Control Number: 94659

Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

2

Federal and State Withholding

Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes.

If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld ($20 weekly minimum for STD/$88 monthly minumum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not axable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For STD ____ .00 weekly ($20.00 minimum)

For LTD ____ .00 monthly ($88.00 minimum)

3

Employee Signature

X _____ __ / __ / ____

Employee Signature — Date Signed

For Internal Use Only

Claim Number _____

* 1 0 6 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

The Employee is responsible for the completion of this form without expense to Prudential Financial.

1

Employee Information

Employer/Association Name: Montgomery County Government

Control Number: 94659

Employee First Name | MI | ***Social Security Number*** ___ - __ - ____

Employee Last Name | Suffix

Employee Address - Line 1 | Birth date (MM/DD/Year) __ / __ / ____

Employee Address - Line 2 | Gender: ○ Male ○ Female

City | State | Zip Code ____ - ____

Occupation

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

X _____ __ / __ / ____

Employee Signature | Date Signed

2

To Be Completed By Attending Physician

Clinical Diagnosis

Primary:_____ ICD-9 Code ___ . __ Pregnancy EDC __ / __ / ____

Secondary:_____ ___ . __

Secondary:_____ ___ . __

Relevant test procedures performed (Please provide results) _____

Surgical procedure(s) performed (Please be specific): Date of Procedure: __ / __ / ____

Current Medications:_____

For Internal Use Only

Claim Number

* 1 0 3 B 0 1 *

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Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number ___ - ___ - ____

2

Attending Physician Information (Cont'd)

Was Claimant hospital confined? ○ Yes ○ No

If Yes, please provide name and address of hospital:

_____

_____

If hospitalized, give dates:
From: __ / __ / ____
To: __ / __ / ____

Other Treating Physicians or Consultants

Physician Name	Specialty	Phone Number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ○ Yes ○ No

Nature of Medical Impairment / Limitation (Please specify nature of corresponding loss of function) _____

_____

_____

Date when significant loss of function occurred: __ / __ / ____

Are there Corresponding Medical Restrictions (i.e., What activities should the claimant not perform because of a significant risk to self or others?)

_____

_____

_____

Prognosis for Return to Function / Return to Work:_____

_____

_____

Return to Work Plan (Please describe): Target Date __ / __ / ____

_____

_____

_____

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number ___ - ___ - ____

2

Attending Physician Information (Cont'd)

Describe Medical Obstacles to Return to Work: _____

_____

_____

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, amily)?_____

_____

_____

Work related illness or injury? ○ Yes ○ No

Was Condition caused by a MVA? ○ Yes ○ No

If MVA, in what state did it occur? ____

First Visit ___ / ___ / ____

Last Visit ___ / ___ / ____

Frequency of Visits: _____

What Job Category best describes the claimant's functional abilities? (Please check appropriate box)

○ **Sedentary**	○ **Light**	○ **Medium**	○ **Heavy**	○ **Very Heavy**	○ **Other**
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

_____

_____

3

Physician Information

Physician Name

Primary Phone Number ___ - ___ - ____

Office Address

Fax Number ___ - ___ - ____

City

State

Zip Code ____ - ____

Specialty

4

Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

X _____ ___ / ___ / ____

Physician Signature

Date Completed

* 1 0 3 B 0 3 *

Prudential Financial

Group Disability Insurance Employer Statement

1 Employer Information

Employer Name: Montgomery County Government

Control Number: 94659

Employer Phone Number: ( ) - ( ) - ( )

Branch Number:

Email Address:

2 Employee Information

First Name | MI | ***Social Security Number*** ( ) - ( ) - ( )

Last Name | Suffix

Address

City | State | Zip Code

Coverage in force when absence began (check all that apply): ○ STD ○ LTD

Employee Phone Number: ( ) - ( ) - ( )

Gender: ○ Male ○ Female

STD Coverage Selected: ○ Core ○ Optional _____

LTD Coverage Selected: ○ Core ○ Optional _____

Date employee became a covered individual for the applicable Coverages:

STD: / /

LTD: / /

Date Hired (MM/DD/Year): / /

Coverage Termination Date: / /

Date Last Worked: / /

Date First Absent: / /

Date Work Was Resumed: / /

Normal Earnings Prior To This Absence (exclude bonus, overtime, etc.)

$, .

Frequency of Normal Earnings

○ Hourly ○ Monthly
○ Weekly ○ Annually
○ Bi-Weekly ○ Other _____

Last Date Employer Paid Any Compensation: / /

Work Hours

Is the employee's work week Monday thru Friday? ○ Yes ○ No

Number of hours worked per normal work week:

If not Mon thru Fri, Check Days Worked

☐ Varies ☐ Wednesday ☐ Saturday
☐ Monday ☐ Thursday ☐ Sunday
☐ Tuesday ☐ Friday

Employment Status

○ Salary
○ Hourly
○ Other _____

Does employee contribute toward the STD Premium? ○ Yes ○ No

If Yes: ○ Pre Tax ○ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

Does employee contribute toward the LTD Premium? ○ Yes ○ No

If Yes: ○ Pre Tax ○ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

For Internal Use Only

Claim Number

* 1 0 2 B 0 1 *

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Disability Management Services
PO Box 13480, Philadelphia, PA 19101
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Prudential Financial

Group Disability Insurance Employer Statement

Employee Last Name

Social Security Number ___ - __ - ____

2

Employee Information (Continued)

Is employee covered under a Prudential Group Life Insurance Policy? ○ Yes ○ No

If Yes, what is the Face Amount? $, , .00

3

Other Income, Deductions & Workers' Comp. Information

Please indicate any applicable deductions, such as Local Tax, State Income Tax, Medical, Dental, Life, 401K, that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, No Fault Auto Insurance, Retirement or Pension Plan. Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance						
State Disability Benefits	☐	☐				
Workers' Compensation	☐	☐				
Other:	☐	☐				
Other:	☐	☐				

Has the employee indicated that the absence is work related? ○ Yes ○ No

Has a Workers' Compensation claim been filed? ○ Yes ○ No

4

Job Information

Occupation

DOT Job Code:_____

What Job Category best describes the employee's essential job duties? (Please check appropriate box)

○ Sedentary	○ Light	○ Medium	○ Heavy	○ Very Heavy	○ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

As the employer, would you be able to accommodate modified duty to facilitate early return to work? ○ **Yes** ○ **No**

If Yes, please explain (reduced hours, job modification, etc):_____

_____

5

Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes the Employee and Attending Physician portions of the claim form.

X _____ __ / __ / ____

Employer Signature — Date Signed

Prudential Financial

Group Disability Insurance
Electronic Funds Transfer Authorization

1

Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at (800) 842-1718.

2

Claimant Information

Employer Name

Montgomery County Government

Claimant First Name

Last Name

Social Security Number

Primary Phone Number

3

Banking Information

Bank Name

Branch Telephone Number

Type of Account (Select One)

○ Savings ○ Checking

Bank Transit Routing Number

(Nine digit bank transit routing)

Bank Account Number

(Bank Account Number)

4

Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner Name

Street Address

City

State

Zip Code

X_____ / /

Account Owner Signature

Date Signed

For Internal Use Only

Claim Number

* 1 1 3 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Electronic Funds Transfer Authorization

Instructions Only: It is not necessary to return this page with your EFT Authorization.

5

Instructions for completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit ransit
routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information".
Please call your bank to confirm that the information you are supplying is correct.

Customer's Name
Street Address
City, State, ZIP

Check No. 1246

PAY TO THE ORDER OF _____ $ _____

Dollars

Bank Name
Street Address
City, State, ZIP

A272078048A 006666D66666C 1246

This is the bank transit routing umber.

It is always 9 digits and appears between the : ymbols.

Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

This is your bank account number. It varies in number of digits and may include dashes or spaces.

The < symbol indicates the end of the account number.

Record the account number in the boxes provided in section 3, "Bank Account Number" and include any dashes and spaces that are within the account number.

If there are any digits to the right of the < symbol (which do not represent the check sequence number), record them in the boxes provided

This is the check sequence number. It may be on either end of your check. Please do not include this on the authorization form.